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SCIENTIFIC COMMITTEE OF THE BATCH B_37 HUMAN MEDICINE

DERMATOLOGY

<https://t.me/dermatology37B>

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للمنقص فينا باقي، والكمال بالمشاركة والتعاون.
في حال وجود أي خطأ أو تعديل، يرجى إرساله إلى بوت اللجنة العلمية:-

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PAPULOSQUAMOUS DISEASES

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PAPULOSQUAMOUS DISEASES

- 1- Psoriasis
- 2- lichen planus
- 3- Pityriasis Rubra pilaris

PSORIASIS

- Papulosquamous chronic skin disease with unpredictable remissions and relapses.
- Mostly affecting adults (14-40 years).
- Incidence: 1-2% of population

Note:

Psoriasis—the disease is chronic so when patient comes and says the treatment is not helping and he doesn't use the medication in an appropriate way its not logical. Must explain to the pt. that this disease is CHRONIC.

The disease is chronic and pt. may live with it life long. When the disease regress pt. can decrease the amount of the treatment. Otherwise pt. remains on the medications.

PROACTIVE FACTORS:

Note:

Proactive factor is Smoke, either directly be smoking or indirectly by cooking using an oven that is run on wood burning.

1- Genetic: Polygenic inheritance(PSORS1), 30% have positive family history, increases with HLA ass B13,BW17, CW6,B27

2- Trauma: Koebner phenomena

3- Infection: Streptococcal infection

4- Weather: Worse in winter

Note:

Trauma—Koebner phenomena—isomorphic response “skin injury can lead to the appearance of psoriatic skin lesion on previously unaffected skin”. This phenomenon is not specific to psoriasis. It also seen in other diseases.

Weather—worse in winter except in Yemen it's not that severe—because people sit in areas with heaters, but in Yemen they go under the sun and UV radiation considered one of the essential treatments so in Yemen not activated in winter.

PROACTIVE FACTORS:

- 5- Endocrine: May exacerbate with puberty, menopause , pregnancy.
- 6- Drug induced: antimalarials, withdrawal of steroids, Lithium, propranolol.
- 7- Emotional stress: 40% of cases
- 8- Obesity , smoking , alcoholism

Note:

Normal cycle of normal proliferation of skin is 28 days, from the basal cell to stratum corneum and shedding.

In Psoriasis takes 5-6 days so the turnover is high in addition to the blood vessel dilatation and increase.

PATHOGENESIS:

- Stimulation: trauma, infection, ...
- Secretion: IL₁, IL8, TNF alpha, interferon gamma, IL 2.
- Response: epidermal hyperproliferation (4-5 day), parakeratosis, Scale formation.
- Capillary dilatation: upper dermis (Auspitz sign)
- Accumulation of inflammatory cells: Neutrophils (microabcesses)

Note:

Skin regeneration takes about (26-28 days) but in psoriasis takes 5 days.

Rapid growth of skin. Due to high vasculature so that causes erythema by dilation of blood vessels—growth occurs with inflammatory factors.

Function of inflammatory factors—secrete mediators such as those that stimulate cell growth, inflammatory cells or blood vessels. Increase inflammation—increases epidermis growth—and increases angiogenesis.

The epidermis doesn't have blood vessels so it takes it's nutrition by diffusion.

Para-keratosis—the cells in the corneum have nuclei due to the turn over growth of psoriasis in (5 days). Reabsorption of nuclei doesn't take place.

In psoriasis—the dermis elongation and enters to the epidermis and it's usually superficial.

CLINICAL PRESENTATION:

- Scaling, and erythematous plaques that may be painful and/or often severely pruritic (QoL)
- Sharply demarcated, erythematous papules and plaques often covered with silvery-white scales
- If the covering scale is removed, a salmon-pink to erythematous lesion is exposed, usually with punctuate bleeding (Auspitz sign)

Note:

Affects the quality of life—causes stress.
Pt. must have skin laceration, or we do not call it Psoriasis. Except if he's taking treatment by corticosteroids.

PSORIASIS VARIANTS:

- Morphological variants:
- Plaque psoriasis
 - Guttate psoriasis
 - Geographical psoriasis.
 - Follicular
 - Annular.
 - Psoriasis Vulgaris
 - Scalp Psoriasis
 - Nail Psoriasis
 - Pustular psoriasis
 - Erythrodermic psoriasis
 - Inverse Psoriasis
 - Psoriatic arthritis.....

Note: Additionally to morphology:

2 cm and above

Secondary skin lesion.

Annular—is circular with the edges affected but clear center.

Discoid—round the lesion takes the peripheral and the central part.

Note:

How to differentiate between Erythrodermic of Psoriasis or other like drugs?

1. By history of patient
2. In psoriasis is very rarely comes in face but in other cases it affects the face.

CLINICAL PICTURE:

Morphological patterns:

1- Plaque Psoriasis (classical type): the most common type affecting around 85% of psoriatic patients.

Note:

Plaque psoriasis found in the extensor surface. It is the most clinical presentation found.



2- GUTTATE

PSORIASIS:

Lesions are the size of drops of water (may follow streptococcal infection).

Most common variant in children.

Note:

Guttate psoriasis—mainly found in the trunk.



Guttate psoriasis



MORPHOLOGICAL PATTERNS:

3- Discoid/annular psoriasis:

Coin shaped lesions



Annular psoriasis



Note:

In annular psoriasis—the lesion is in the periphery while the center is clear/empty.

MORPHOLOGICAL PATTERNS:

Geographical psoriasis: curved large lesions in the back

Follicular psoriasis: adult females and children (around the hair follicles) located in the thighs

Linear psoriasis : Koebner's phenomena

MODIFICATION BY SITE

1- Scalp psoriasis: band like lesions in the anterior border of hair line

2- Flexural psoriasis(inverse): Affects flexures(sub mammary, groin, axillae),itching , redness and no scales.

3- Palmoplantar psoriasis:

- Pustulosis

- Thick fissured plaques

- Typical silvery plaques

- Sole rupioid form

Scalp Psoriasis: we advise the pt., while taking the treatment, not to comb his hair—because that will increase the itching of the head and not to go to the Arab baths, because with humidity the itching increases.

Note:

How to distinguish between Scalp Psoriasis and seborrhaic dermatitis?

1. Type of skin
2. Delay of erythema

In seborrhaic dermatitis—inflammation of the skin with few redness and oozing vesicle which cause chronicity and change of the skin.

Seborrhaic distribution—means takes areas which are rich in sebaceous glands such as the scalp, face, behind the ears, intertriginous area.

Flexural Psoriasis—decrease or absent due to friction and moisture.

Pusutulosis—there is sterile pus due to micro abscess of neutrophils collection (no organisms).

Additional Lecture notes:

Thick Fissured plaques

In creep feet

It's found in the pressure area

In Psoriasis

Found in the arms and other areas not in pressure area.

In sole rupioid form—thickness and redness.

MODIFICATION BY SITE

4- Nail Psoriasis: pitting , ridges , grooves , onycholysis , subungual hypertrophy

5- Psoriatic arthropathy: rheumatic factor negative arthritis

6- Erythrodermic psoriasis: Precipitated by infection, hypocalcemia, antimalarials , CS withdrawal(ER); sparing of face , 90% of body involvement, leukocytosis, ESR,

Note:

Psoriatic arthropathy—pain in joint this is found in small joints, sometimes causes dystrophic joint.

When treating it, we should give systemic because the topical is not beneficial due to the inflammation that is internal. Ex. Of a drug is methotrexate.

MODIFICATION BY SITE

7- Sebopsoriasis:

Usually, seborrheic distribution

8- Mucosal lesions: more in pustular psoriasis

9- Pustular psoriasis: precipitated by irritating topicals, hypocalcemia and pregnancy.

Note:

Sebopsoriasis—from topical type it is seborrheic distribution but psoriasis lesion.

Psoriasis lesion—elevation on skin but the distribution with seborrheic.

Pustular psoriasis—is little reaches 5%-10% maximum.

Irritating topical means that the cause of irritation is by some old drugs like Anthralin—cause high inflammation—formation of neutrophils—increase pustular psoriasis.



Acta Derm Venereol 2015;95:100-4



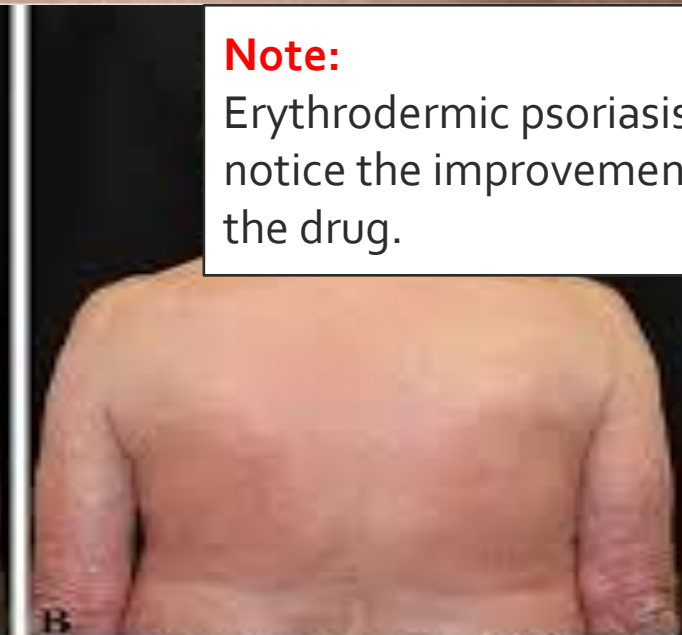
Week 0

Week 8

Week 52

Note:

A—flexural psoriasis we notice the skin elevation.



Note:

Erythrodermic psoriasis: we notice the improvement using the drug.

A

Note: Palmoplantar psoriasis

A. Thick fissured plaques

B. Pustulosis

C. Sole rupioid form—characterized by thickens of skin with existence reguration and erythema.

To differentiate between them and tinea pedis by dermoscopy. And tinea pedis occurs usually in the arch of foot.

B**C****(b)**

TYPES OF PSORIASIS

PLAQUE PSORIASIS: 80% OF CASES

Sharply demarcated, red scaly patches of skin with a silvery sheen

SCALP PSORIASIS: 45%-56% OF CASES

Raised red or silver scaly plaques on the scalp, which are often itchy

NAIL PSORIASIS: 50% OF CASES

Fingernails and/or toenails appear dimpled (imagine a golf ball)

GUTTATE PSORIASIS: 10% OF CASES

Skin on arms, legs, and torso is dotted with hundreds of small scaly lesions

INVERSE PSORIASIS: >10% OF CASES

Develops in skin folds like armpits, bellybutton, and more intimate body parts, including the genitals

ERYTHRODERMIC PSORIASIS: 2% OF CASES

Lobster-like redness from head to toe with peeling and scaling; can be extremely dangerous

PUSTULAR PSORIASIS: RARE

Dangerous form that covers widespread areas (including hands, feet, and torso) with pus-filled bumps





Mild psoriasis
Less than 3% of the
body has psoriasis



Moderate psoriasis
3-10% of the body
has psoriasis



Severe psoriasis
More than 10% of the
body has psoriasis



=
1%

TREATMENT OF PSORIASIS

A- Topical ttt:

- 1- Topical corticosteroids: mono or in combination
- 2- Calcipotriol: mono or in combination
- 3- Dithranol
- 4- Tar
- 5- Tazarotene
- 6- Salicylic acid 3%

Note:

Pt. should use Tar—shampoo
Tazarotene, vit. A derivative
3rd generation effect keratinisation.

TREATMENT OF PSORIASIS

B- Phototherapy: UVB(burn), NB UVB(311-313) , P(Psoralens)UVA (skin cancer)

C- Systemic treatment:

- 1- Methotrexate: BM suppression, indigestion, liver damage
- 2- Acitretin: teratogenic, lip dryness, hyperlipidemia
- 3- Cyclosporine: HTN, skin cancer, Renal toxicity

D- Biologicals: Alefacept, Efalizumab, Etanercept, adalimumab.

E- Immunological treatment: Ustekinumab

Note:

Phototherapy—is very important.

UV:

- UVA—carcinogenic in exposure for a long time.
- UVB—carcinogenic less than UVA.
 - It's function"
 - Activation of Vit. B
 - Activation of keratinization
 - Decrease immune response—this is important for treatment.

Methotrexate—doctors prefer it because it is cheap and gives a good result but gives with folic acid because it is antifolate (anti-metabolic)

If pt. wants to become pregnant, treatment should be stopped for a period of three months for both sexes, for a man and a women because the drug is teratogenic.

If the women is sick while she is pregnant, we will suffice with topical treatment (calcium and Vit. D).

Methotrexate—is given in a small amount of 15mg per week. Contrary to what we use for autoimmune diseases dose starts at 30mg per week.

LICHEN PLANUS

- An idiopathic, chronic, papulosquamous, inflammatory, immune mediated skin disease that affects the skin, oral mucosa, genital mucosa, scalp, and nails.
- Lichen planus lesions have the six P's (planar [flat-topped], purple, polygonal, pruritic, papules, plaques); shiny.

Note:

Self limiting.

But the patient itches all day and the patient gets upset because he doesn't look nice and penetrates oral mucosa known as Wickham striae.

LICHEN PLANUS

- Acute condition, affecting the flexor surfaces of the wrists, forearms, and legs, nails (10%) and MMs(70%). The lesions are often covered by lacy, reticular, white lines known as Wickham striae.
- Can occur at any site of the body Ch by Acanthosis, saw tooth thickening of the epidermis
- Affects 1% of adult population.

LICHEN PLANUS

- Oral lesions are common; 50-70%
- Nail lesions: 10%, nail ridging, grooving, striations, characteristic : pterygium formation. Fusion of the proximal nail fold with the nail bed
- Hair involvement: lichen planopilaris, can cause atrophy and permanent hair loss

Note:

Pterygium formation—scar and fibrosis may form.

CLINICAL VARIANTS OF LP

- Annular: glans, axillae and groin
- Actinic (tropicus): children and young adults.
- Oral erosive or ulcerative: painful, recalcitrant to ttt, HCV associated.
- Atrophic: may be due to resolution of LP lesions, at LLs mostly(lichen sclerosis et atrophicans).
- Lichen striates



Note:
Actinic—no reaction but hyperpigmentation in exposed areas.



CLINICAL VARIANTS OF LP

- Bullous lichen planus
- Guttate LP: good prognosis
- Inverse LP
- Hypertrophic lichen planus: severely pruritic in the extremities with hypertrophy.

Note:

Inverse LP—comes in areas such as axilla and groin.

Must distinguish it from Hypertrophic LP, tinea and neurodermatitis.

CLINICAL VARIANTS OF LP

- Follicular LP.

CLINICAL PICTURE



- Papule
- plaque
- Purple
- Polygonal
- Plane
- Pruritic



MANAGEMENT

- High-potency topical corticosteroids
- Oral corticosteroids (prednisone)
- Phototherapy
- *Acitretin*
- Topical calcineurin inhibitors.
- Antihistamines and tranquilizers

Note:

Topical corticosteroids—most important
Topical calcineurin inhibitor—because if this patient is easily agitated will cause case to become worse.

PITYRIASIS RUBRA PILARIS

Disorder of keratinization involving children and adults

Clinically there are 5 subtypes where the classical types are characterized by:

- 1- Follicular hyperkeratosis on erythematous base(first on Knees, elbows)
- 2- Waxy yellowish keratoderma of the palms and soles.

PITYRIASIS RUBRA PILARIS

- 3- Scaly scalp
- 4- Scaly erythema of the face and neck
- 5- Erythroderma may develop.
- 6- Islands of normal skin.
- 7- Nail changes (thickened, brittle, striated)

PITYRIASIS RUBRA PILARIS



Figure 1: (A) Confluent, red-orange, waxy plaques on the palmar aspects of the hands of a 34-year-old woman with pityriasis rubra pilaris. (B) Similar red-orange plaques on the plantar aspects of the feet.

TREATMENT OF PRP

- Topical corticosteroids and salicylic acid.
- Vit A 150,000-300,000 IU /day
- Accutane 1-1,5mg /day
- Methotrexate 10-25 mg /week
- Narrow band UVB
- PUVA or Re-PUVA.

PITYRIASIS ROSEA

- Self limiting eruption seen mainly in adults
- Caused by HHV6,7
- More common in females and in spring and Autumn.
- Clinically: Herald patch (sharply defined, bright red, covered by collarette of scale at the periphery of the lesion)

Note:

Must distinguish it from Tinea Barbae
Herald patch 3-7 days in children affects chest and trunk.

PITYRIASIS ROSEA

- Lesions occur in charismas tree pattern, mainly in the trunk, neck, upper third of the arms,
- Fades with in 3-7 weeks.
- C/varieties: inverse, generalized, typical

PITYRIASIS ROSEA



PITYRIASIS ROSEA

Management:

- Re-assurance,
- Emollients ,
- Topical corticosteroids,
- Antihistamines

THANK YOU